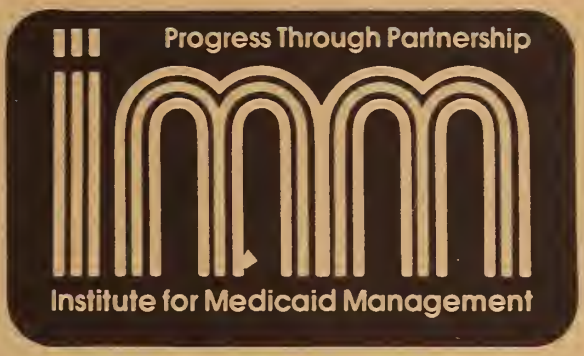

Manual—Independent Professional Review

September 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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Prepared for:

THE INSTITUTE FOR MEDICAID MANAGEMENT
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INDEPENDENT PROFESSIONAL REVIEW:

A Strategy for Assessing the Quality of Resident Care in Intermediate Care Facilities for the Mentally Retarded

September, 1977

Prepared by:

PACIFIC CONSULTANTS
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PREFACE

The purpose of this manual is to explore the considerations involved in performing Independent Professional Reviews (IPR) in Intermediate Care Facilities for the Mentally Retarded (ICF's/MR).

Guidelines, containing regulation-by-regulation instructions for implementing Independent Professional Reviews of ICF's, have been drafted at the Federal level. As noted in the introduction to the draft guidelines, "...much of the information in these guidelines will be useful for review in the Intermediate Care Facility for mentally retarded. The critical difference between the Intermediate Care Facility general resident and the Intermediate Care Facility mentally retarded resident is the nature of the individual's disability."

The Independent Review Process in ICF's and ICF's/MR have much in common, particularly in terms of <u>form</u>. Both are independent professional reviews of the quality and appropriateness of care provided to meet the needs of individual residents. And all residents of ICF's have a number of needs in common.

On the other hand, the two processes do (or should) differ in terms of <u>specific content</u>, since reviewers must be aware of--and responsive to the unique characteristics and disabilities of the populations being served. However, the special issues deriving from the characteristics and disabilities of mentally retarded individuals have not been addressed in depth in the draft guidelines. This manual is therefore intended to serve as a <u>supplement</u> to the IPR guidelines. It focuses on those aspects of the review process which are uniquely relevant to the mentally retarded population. It portrays State practices in reviewing ICF's/MR. And it identifies some of the issues associated with these reviews.

It is important to note, however, that this is not a "how-to" manual. It does not provide step-by-step guidance. Nor does it repeat the specific information on the regulations covered by the guidelines. Instead, the emphasis is on concepts, approaches, strategies and suggestions which may be helpful to IPR teams in performing individual reviews of residents in Intermediate Care Facilities for the Mentally Retarded.

Organizations and procedures, concepts and criteria pertaining to the assessment of quality, and considerations about determining the appropriateness of level of care are also discussed. It is hoped that these discussions will yield suggestions which States can adapt and apply to their own needs.

The manual was prepared in draft form in August, 1977. The perspectives put forward in the draft are based on extensive interviews with administrative personnel and IPR team members in five states, direct observation of the IPR process in four States, analysis of the IPR instruments in use in sixteen States, review of the relevant regulations and literature, attendance at a training session for ICF/MR surveyors, and consultation with appropriate Federal officials. The completed draft was then reviewed by Federal officials and submitted to a nationwide conference for additional comment. The conference on assessing quality of care in ICF's/MR was held in Kansas City, Missouri, September 6-8, 1977. There was broad representation from States, Regions, and the central Federal office.

Two substantive issues, pertaining to the subject matter of the manual, were given major attention at the conference. First, there was considerable discussion about the need for criteria in addition to the regulations. While some participants expressed the belief that the regulations themselves are sufficient (especially from a facility standpoint), most felt that there was a need for additional tools to aid IPR teams in interpreting the regulations in a consistent manner. The concepts put forward in this manual were generally seen as a valuable first step in this direction. In addition, it was recommended that a State Task Force be formed to carry the process further.

Second, the possibility of developing a standardized assessment form was considered. Most participants indicated that a model form would be useful, so long as States were free to use, adopt, or ignore the model--depending upon their needs and performances.

Finally, numerous conference participants indicated that development of a training program for IPR teams would be the most valuable form of assistance.

A number of specific suggestions for improving the manual were made at the conference, and these have been included in the final version. Also, a questionnaire on State practices was circulated at the conference and was completed by representatives from 20 States, in addition to the five which had been visited. This additional information on State practices has been tabulated and included in Chapter II.

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I. INTRODUCTION

As defined by the American Association on Mental Deficiency, "Mental Retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period." In other words, mental retardation is a condition--characterized by intellectual and adaptive deficits. While mentally retarded individuals are frequently beset by physical and sensory problems as well, mental retardation *per se* is not an "illness."

Nonetheless, until very recently, most mentally retarded persons, whose families were unable to cope with the burden of their care, were placed in State hospitals. These "Hospitals" were typically large, physically isolated institutions, and the care which they provided was generally custodial in nature.

FEDERAL LEGISLATION AND STANDARDS

A major change was introduced with the passage of Federal legislation establishing Medicaid-supported Intermediate Care Facilities for the Mentally Retarded. Under this legislation:

- Mental Retardation was acknowledged to be a condition which is responsive to active treatment
- Standards were established, and matching funds provided, to upgrade the quality of care provided in institutions for the mentally retarded
- The potential was created for developing, certifying and supporting a continuum of institutional facilities--including both the former state hospitals and an array of community-based facilities (both large and small)

Specifically, the legislation and the accompanying regulations* (published in 1974 and slated for full implementation in 1977) established special standards for Intermediate Care Facilities for the Mentally Retarded as a subset of Intermediate Care Facilities in general. These standards set forth very explicit requirements for normalization of the living conditions of mentally retarded residents and for implementation of a full range of professional services geared to provision of active treatment to aid each mentally retarded resident to achieve his/her maximum potential developmentally, socially, and physically.

These standards represent a significant shift away from the ones covering skilled nursing facilities (SNF's) and regular Intermediate Care Facilities.

The focus in SNF's is appropriately the provision of needed medical and nursing services, directed toward remedying or alleviating a variety of physical pathologies. The focus in regular ICF's is the provision of needed supportive medical and nursing services, coupled with major attention to the quality of life (for residents who are likely to remain in the ICF's for the balance of their lives).** In ICF's/MR, in addition to the focus on normalizing the living situation, and providing for social and medical needs, there is also a new focus on treatment directed toward upgrading the functional level of each resident.

These standards are generally reflective of the most current and advanced professional thinking with regard to the kind and quality of care which is most appropriate for mentally retarded residents in institutional settings.

In practical terms, the ICF/MR standards have posed several problems. First, some privately operated, community-based regular ICF's have been reluctant to

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* CFR 45 Public Welfare 249.13

** It should also be noted that, in actual practice, placements in SNF and ICF facilities do not always correspond to this conceptual formulation but are frequently influenced by bed availability, family or physician preference, and other factors.

seek certification as ICF/MR facilities, because they believe that the provision of the full range of mandated services will be difficult and/or unduly costly. Secondly, State-owned institutions are frequently housed in very old buildings, and costly modification will be required to bring them into compliance with the new standards. One result has been for State institutions to seek certification for only those portions of the facility which can be brought into compliance without excessive cost--this, in turn, has tended to create a dual standard of care, in some facilities.

Yet, the standards should provide a powerful impetus to undertake the corrective actions which State facility directors have long deemed necessary. However, since the standards are only now coming into force, it is premature to attempt to assess their full impact.

REGULATORY MECHANISMS

Concurrent with the adoption of the special regulations for Intermediate Care Facilities for the Mentally Retarded in 1974, a number of federally-mandated regulatory mechanisms were set into motion. Together, these were intended to ensure that the Intermediate Care Facilities for Mentally Retarded would provide the level of care stipulated by the regulations--to eligible and appropriate persons--as follows:

The Medicaid agency was charged with the responsibility for eligibility determination, administration of the review processes (directly or through contractual arrangements), and fiscal control (specifically, the Medicaid agency is empowered to provide, or withhold Medicaid reimbursement to ICF's/MR for the care of Medicaid-eligible residents).

State surveyors, from State health departments, were charged with responsibility for surveying and certifying facilities on the basis of their compliance with the regulations. Specifically, surveyors are empowered to certify facilities as ICF's/MR, based on their determination that the facility has the environmental and programmatic capability for delivering (to all of its residents) the quality of care specified by the regulations. Surveyors were assisted in the performance of this task by the development of standardized national

form and a series of training sessions. The survey is repeated annually and covers all facets of the facility and the facility's capability for delivering the level and quality of service specified in the regulations.

Utilization Review and Control Procedures were applied to all ICF and ICF/MR facilities. These entail a semi-annual professional review of residents, to verify that they continue to require the level of care provided by Intermediate Care Facilities.

Independent Professional Review. As in Medical Review, the IPR program has two distinct parts involving separate administrative processes:

The first is a requirement for an INTERDISCIPLINARY EVALUATION of an individual's need for care in an Intermediate Care Facility, prior to admission or authorization for benefits.

The second part of the Independent Professional Review program consists of PERIODIC ON-SITE VISITS to assess the care the resident is receiving. The primary goal of the resident-centered, on-site review is an appraisal of the services rendered to each resident--to determine if they are timely, in conformity with accepted professional standards, and both adequate and appropriate to meet the resident's needs (i.e., an assessment of the quality of care).

A secondary goal involves matching the kinds of services actually needed by the residents with the facilities most capable of rendering such care (i.e., a determination of the appropriateness of placement). On-site reviews of each resident must be conducted at least annually. IPR teams are not expected to evaluate the facility or services, except in relation to the needs of individual residents. They do not have the authority to "close down" a facility, but their report may result in a Medicaid agency decision to withhold Medicaid payments or to transfer patients out of the facility.

According to the regulations, the on-site IPR and Utilization Review functions may be combined, provided that the teams are properly constituted and independent of the facility being reviewed.

IPR ON-SITE ASSESSMENT OF RESIDENT CARE

The subject of the present manual is the Independent Professional Review on-site assessment of resident care. The other processes involved in fiscal and quality control have been briefly reviewed because of the complex inter-relationships which exist among these functions.

Perhaps the most difficult area has been the precise differentiation between the survey process and the IPR on-site review. Thus, while the guidelines clearly specify that the survey process is facility-oriented and that the IPR is resident-oriented, both are involved with assessing service quality, and the potential for overlap and confusion, in practice if not in theory, is great. A number of concerns about the relationship between the two functions was raised by IPR teams and administrators and by facility personnel--especially with regard to variations in terminology and perceptions. It is hoped that the present manual, and the national IPR conference,* can contribute to greater clarity--and perhaps to greater cooperation--in relation to these two functions.

There also seems to be considerable variation in the relative importance placed on assessing the quality of care *vs.* determining the appropriateness of care. In some States, IPR program personnel place primary emphasis on efforts to upgrade the quality of care within ICF's/MR. In a sizeable number of States, however, the emphasis of the IPR program is directed toward identifying individuals who have the potential for transfer to lower levels of care. This latter interpretation seems to derive from the linkage between Utilization Review (UR) and IPR, and/or from a conviction that reducing cost is a high priority. An article entitled The Quandary of Quality Assurance refers to

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* Problems and approaches to survey-IPR coordination received considerable attention at the IPR conference.

See the Conference Proceedings for a further discussion of this issue.

this issue as follows:

> At this stage of its development, quality assurance suffers from a variety of conflicting and overlapping interests--e.g., government providers, professionals, carriers, accrediting agencies, consumers, planners and foundations. In this framework, it is interpreted variously as a way to save money, improve care, protect prerogatives, establish long-range roles and solidify institutions.*

This issue will be more fully discussed in the manual section on Determining the Appropriateness of Placement (Chapter IV).

A final issue, which must be briefly addressed, pertains to the historic development of the IPR program. IPR grew out of the concept of professional reviews in skilled nursing facilities (i.e., Medical Reviews). The IPR in ICF's/MR is further development of the general IPR process. As a consequence, there is a tendency to utilize the same (or similar) personnel, procedures, and instruments in reviewing mentally retarded residents as those used in SNF's and regular ICF's. Concern has frequently been voiced that this historic linkage to Medical Review has tended to produce an emphasis on the medical model at the expense of the developmental model, which is considered more relevant to the MR population.

The present project is directed toward examining the IPR in light of (and with very special attention to) the particular characteristics and needs of mentally retarded residents in ICF/MR facilities. Section II of this report will describe the organization, staffing and procedures of the IPR program in five, very active States which we visited; Section III will focus on the quality of care; and Section IV will deal with determining of appropriateness of placement.

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* McNerry, Walter J., The Quandary of Quality Assurance, A special article in the New England Journal of Medicine, December 30, 1976.

II. HOW THE IPR WORKS

This chapter describes the organization, staffing and procedures used in the IPR process, based on in-depth information provided by the five States visited and questionnaires completed by twenty additional States.*

STAFFING FOR THE IPR

It is generally assumed that the IPR is conducted by Medicaid agencies and that the survey is conducted by Health Departments. In practice, the five States visited revealed several different organizational frameworks, including States where the IPR is conducted by the Medicaid agency, States where the IPR is conducted by the Health Department under contract to the Medicaid agency, and one State where the IPR was conducted by a subsidiary of the State medical association under contract to the Medicaid agency. In all five States, the IPR is administered by the Medicaid agency--either directly or through contractual arrangements. And, in these five States, the IPR teams are different from survey teams, even where both functions are performed by the Health Department.** While different teams perform the survey and the IPR, the same teams generally perform all of the professional reviews--in SNF's, in general ICF's and ICF's/MR.

Composition of the Teams

All of the twenty-five States about which we have

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* The questionnaires were completed at the IPR conference in Kansas City, in September, 1977.

** At the Conference, it was learned that, in a very few States, there are teams which do both surveys and IPR's.

information include nurses and social workers on their basic IPR teams. A few States use larger teams, with more disciplines represented (e.g., teachers or psychiatrists). In addition, most of the States have varying provisions for using consulting physicians and/or other specialists in some aspect of the review process.

1. The Nurse/Social Worker Core Team

All of the States utilize highly qualified RN's for the nursing member of teams. While some of the nurses have specific psychiatric training and most have had considerable prior work experience in various capacities, less than half have specific MR training or experience.

There is significantly more variability in the academic preparation of the "social worker" member of the teams. Seven States have all MSW's; seven have all BSW's; four have both MSW's and BSW's; four have MSW's, BSW's and BA's in related fields; and three use only BA's. Insufficient salary was cited as the primary problem in recruiting the preferred MSW-level personnel. The fact that very few of the "social workers" have had specific training for or direct prior experience with the mentally retarded was also cited as a weakness.

2. The Consulting Physician

None of the States visited are using physicians as full time core team members in completing the individual reviews. Most of the State respondents, however, indicated that the utilization of consulting physicians is crucial for maintaining the IPR team on a "peer" footing with the medical staff of the facilities, particularly in cases where there is a difference of opinion between the team's recommendations and the views of the facility staff.

A majority of all States have consulting physicians who participate in the review of selected residents. In several States visited, consulting physicians are regularly utilized at the termination of each

facility review to examine residents identified by the team, to assess the team's recommendations, and to discuss medical issues with the team and facility staff. In these States, the physician also frequently participates in the exit interview with facility staff.

Virtually none of the consulting physicians have specific training or experience in connection with mental retardation, although some have had experience with long term care residents. In fact, it appears that the same consulting physicians who are utilized for SNF's and general ICF's are also generally utilized for ICF's/MR.

3. Other Consultants

Approximately twenty percent of the States use psychologists as regular consultants. With the exception of two States (where the psychologist is a regular member of the core team) the role of the psychologist appears to be similar to that described above for the physician (i.e., he/she comes in on the final day to review specially identified cases). In addition, IPR teams generally have access to a variety of other specialists (e.g., pharmacists and physical therapists) on an "as needed" basis -- but they do not regularly participate in the IPR process. Very few of these consultants were identified as having had special experience with MR's.

4. Involvement of Qualified Mental Retardation Professionals (QMRP's)

As noted earlier, there are relatively few IPR core staff members who qualify under the regulatory definition of QMRP's (i.e., fewer than half of the nurses and only a handful of social workers were characterized as QMRP's). This is to be expected since most of the States are using regular ICF teams for the ICF/MR reviews. Six of the twenty-five States for which we have information do add a QMRP to the core team when they visit ICF's/MR.

Several factors were cited in connection with involving QMRP's in the review process, including

ambiguities in the regulations pertaining to the definition of QMRP's, difficulty in recruiting professionals with expertise in mental retardation, and the cost of hiring special (extra) staff with expertise in mental retardation to participate in the ICF/MR reviews.

Deployment of Staff

The number of review teams per State in the five States we visited ranged from a low of three teams to a high of twelve teams. The number of teams allocated by each State depends on the total number of facilities within a State, their size, the frequency with which the reviews are undertaken, and the time required for each individual review.

Given the size of the States and the time required for travel, most of the States deploy the teams on a geographic basis, with each team performing the reviews within a specified region.

In most States, the same teams are responsible for conducting professional reviews in SNF's, regular ICF's and ICF's/MR.* Six of the twenty-five States use special teams for reviewing ICF's/MR. Generally, States do not have a sufficient number of ICF's/MR to permit specialization, and team members seem to prefer diversity of assignment.

Training of Staff

Most of the States rely primarily on on-the-job training by experienced team members to orient and train new team members. Additional in-service training ranges from no formal training (in twelve of the twenty-five States) to training sessions every five or six weeks, lasting for one and a half to two days each. The most frequently cited content areas covered by the training included: information pertaining to the regulations, discussion of review procedures and

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* With the exception that in several States, QMRP's are added to the core team during the time they are reviewing ICF's/MR.

criteria, and discussion of specific problems encountered by the teams. More training on mental retardation as well as on specific criteria for conducting the professional reviews were cited as important needs. In this connection, many respondents stated that a Federally organized training program, similar to that organized for the surveyors, would be helpful.*

PROCEDURES PRIOR TO THE VISIT

There was a high degree of consistency among the five States visited in terms of the overall procedural steps utilized to complete the professional reviews. Each of these steps is described below.

Notification of the Facility

All five States notify the facility before the teams arrive. Typically, this involves an advance letter to the facility several weeks before the site visit, which states that a review is scheduled but does not specify the precise date. The advance letter is then followed by a telephone call to the facility within forty-eight hours of the actual site visit.**

Securing a Listing of Residents

Most of the States secured the listing of Medicaid residents to be reviewed directly from the facilities rather than the single State agency.*** Generally, the notification letter is used to request that the facility prepare a listing of residents.

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* The desire for such training was also repeatedly emphasized at the IPR Conference.

** One respondent noted a potential problem in this regard. If the facility listing is incomplete, then there is the possibility that some residents will be omitted in completing the reviews. Conversely, in the one State which uses both facility and Medicaid lists, it was noted that the facility listings are frequently the more accurate, due to the time lag involved in making computer additions and changes at the Medicaid agency.

*** The desirability of unannounced and/or off-hours visits was discussed at the Conference, but we have no specific information on the extent of these practices.

In several of the States, the facility is also asked to complete a portion (or all) of a face sheet on each resident. One of the States noted a tendency to ask the facilities for more and more face sheet information each year. In another State, a dual process is used, wherein the facility and the reviewers both complete a number of items (with separate boxes for each). This permits a comparison between the assessments made by facility personnel and those made by IPR team members, on the same items. Discussion of discrepant ratings contributes to communication between the facility and the reviewers about the meaning of the items in question, and this communication, in turn, increases the facility's capability for assessing its own performance.

ON-SITE REVIEW PROCEDURES

All of the States review each facility at least once a year and approximately one half of the States do semi-annual reviews. These six-monthly reviews are generally utilized to fulfill the requirements for UR as well as IPR.

The overall process for conducting the professional reviews is similar across the five States visited, including: (1) an entry interview; (2) individual assessments; and (3) an exit interview.

The Entry Interview

The teams in all of the States conduct entry interviews on the first visit to a facility in order to brief facility administrators concerning the professional review objectives and procedures. Most of the States indicated that this initial entry interview is particularly important, since many facility personnel are somewhat anxious about the nature of the professional reviews. The entry visit is generally very brief or entirely eliminated during subsequent reviews.

Individual Assessments

Except for the entry and exit interviews, virtually all of the time spent at each facility is devoted to the

review of each and every Medicaid-supported resident within the facility. The estimated time per resident spent on each individual assessment ranges from ten to sixty-five minutes.* In a very large State-operated facility, a single team may spend as much as several months to complete the reviews while in a small community-based facility the reviews might be completed in several hours.

The following discusses the instruments and sources of information used to complete the individual assessments.

1. Instruments

In the absence of a standardized national instrument, the forms used by the States to complete the individual assessments differ greatly in terms of length, type of items included, and relative emphasis. Some State forms are one page while others are ten pages or longer. Some are fully pre-coded checklists; some are completely open-ended; and some include a combination of check-off and narrative items. Ten of the States for which we have information use the same forms in ICF's/MR that is used in regular ICF's; fifteen use a special form in ICF's/MR containing items pertaining to the mentally retarded (e.g., with reference to plans of care and active treatment). Based on the forms which we have examined however, it should be noted that the number of items relating to the mentally retarded are generally minimal. As a consequence, attention to active treatment and normalizing experiences for the mentally retarded are generally given less attention than medical care and other aspects which are more specifically appropriate to SNF's and regular ICF's.

2. Sources of Information

Five overall sources of information are used to complete the individual assessments. These include: (1) the facility face sheet; (2) resident records; (3) observations/interviews

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* One State indicated that the amount of time needed was three hours per resident.

with residents; (4) observations/interviews with facility staff; and (5) general impressions. Each of these sources is described below.

The Facility Face Sheet. As noted previously, several States utilize face sheet information completed by the facilities. While the amount and kind of information requested on the face sheets varies, it is sometimes quite extensive -- including information on the resident's basic demographic characteristics (e.g., age, sex, marital status), admission data (e.g., admission date, previous facility placements) and information on services currently being received. In one State, facilities are requested to provide information pertaining to the presence and completeness of the individual resident assessments and plans, although this information is subsequently verified by the review teams. While the practice of having facilities provide some basic face sheet information can produce a savings in time, it should be noted that, if the practice were to go too far, the review process could lose much of its force as an external review.

Records. In all but one of the States visited, the review of individual records is conducted prior to any contact with residents. Basically, the States use the record reviews to complete as much of the review forms as possible, reserving resident and staff contact to provide information not contained in the records and/or to verify the information gleaned from the records.

Both the nurse and social worker members of the teams participate in the record review. Typically, the nurse focuses primarily on the medical aspects of the record while the social worker focuses on the more psychological and social aspects of the record, although we noticed a great deal of constructive sharing among the team members that we observed.

Team members and administrators in all of the States stressed the difficulty and complexity of completing the record reviews. Given the nature of the records -- their extreme bulk and the many variations in organization and completeness

across facilities, even within the same State--the record review process is by far the most time consuming task in the review process. The record review averages two to four times as long as the time spent in direct resident contact--across all of the States.

Observation/Interviews with Residents. All of the States for which we have information have provisions for resident contact. In the States visited, this consists of observation of the more severely retarded residents and both observation and abbreviated interviews with less severely retarded residents.

In general, the contacts are extremely brief and consist of such questions as: What did you have for lunch? What did you do today? Do you like it here? While the intent is to verify/clarify information contained in the record, there is rarely the opportunity (or the potential for verbal communication) which would be required to accomplish this.

Given the extremely limited time available for observations/interviews with each individual resident, team members generally felt that notes (based on the record review) helped to guide the observations/interviews. Similarly, most team members felt that it was highly desirable to observe/interview residents at many different times and places, insofar as possible. Numerous respondents indicated that the time spent with residents was insufficient for adequate assessment (beyond the appearance of cleanliness or contentment) and that they therefore had to rely primarily on information contained within the record.

Observation/Interviews with Staff. Most of the twenty-five States also utilize facility staff as a source of information. In the States which we visited, this generally consists of casual observations of staff practices and unstructured interviews with staff pertaining to specific residents. Again, the major intent is to verify and/or clarify information contained in the record, but only one of the five States places major

emphasis on "structuring" the team's contact with the staff. In this State, the charge nurse or "head" caretaker is interviewed in connection with each resident.

General Impressions. While not a formal source of information during the facility visit, the team member's general impressions of the facility, its staff, and the quality of care provided, seem to have an effect on the team's assessments pertaining to specific residents. Thus, each facility seems to possess an ambience which can and does influence the team's individual assessments.

The Exit Interview

All of the States visited conduct exit interviews with the facility staff; however, the nature of the interviews varies across States. In several States, major emphasis is placed on reporting individual resident-related deficiencies uncovered in the review process and providing the facility with advance notification of the content of the written report. In other States, the emphasis is more on providing consultation and technical assistance in an effort to stimulate the facility to correct a pattern of deficiencies. Generally, the nature of the exit interview in a specific State corresponds with the approach taken in preparing the written summary.

Summary Report and Feedback to Facility

All of the States visited provide formal written feedback to the facilities in addition to the exit interview. Feedback is provided by the Medicaid agency, even in cases where the performance of the reviews has been contracted to another agency. In these cases, the contracted agencies generally send the written feedback to the Medicaid agency, which then forwards it to the facility.

While all of the States provide written feedback to the facilities, the nature of this feedback varies considerably. In one State, nothing is provided to the facilities beyond a listing of all residents for whom

there was an unmet need. Another State sends a computerized print-out of deficiencies for each resident and the individual assessment forms. In the remaining States, a narrative summary report is sent to the facilities which describes patterns of inadequate care, based on the individual resident needs uncovered in the review process. One of these States also sends the individual assessment forms for each resident. Similarly, of the twenty States completing the questionnaire, seventeen returned a narrative report to the facilities. Most of these States also send either the individual assessment forms or a checklist, or both. While there was certainly no consensus on the appropriate form and content of the summary report, most respondents tended to feel that the provision of technical assistance is an important function and that specific guidance can be communicated through the use of some narrative. In order for a narrative format to be effective, however, it is essential that an outline be provided--to ensure that each team is covering the same basic information--and that individual resident reports be included in all instances where specific action is required.

The major function of the reports is to provide formal feedback on the results of the review process as a basis for initiating corrective action. Several respondents also cited several other potential uses. These included utilization of the material for: (1) documentation during follow-up, (2) aiding facilities in upgrading care, (3) assessing patterns of need across the State, and (4) influencing the legislature in funding needed services.

Facility Response*

All of the States visited require that the facilities respond with a written plan for remedying any resident-related deficiencies cited in the written report, and all States require the facilities to respond to any recommendations pertaining to change in level of placement.

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* Most personnel interviewed referred to the required facility response as "a plan of correction" though this terminology usually is associated with the survey process.

For the most part, the respondents believed that the facilities offering the "best" care were the most open to the recommendations contained in the written report.

Follow-Up

Follow-up is generally conducted on the teams' next scheduled visit to the facility. Thus, the lapse of time between the initial review and the follow-up could vary anywhere from six months to a year, depending on whether or not the State reviews facilities once or twice a year. In addition, several States conduct follow-up visits ninety days after a facility submits its plan of correction. In one State, follow-up is conducted through a facility-completed follow-up form. All States conduct special follow-up visits when the teams encounter cases involving extraordinary problems.

COMMENTS

A number of States offered comments about inter-rater reliability in the review process, how much clout the Medicaid agency has over the facilities, time constraints, and the judged effectiveness of the review process. Each of these topics is addressed below.

Inter-Rater Reliability

Respondents in most of the States cited problems pertaining to inter-rater reliability--between team members within a single team and among different teams across the State. Thus, most respondents acknowledged that explicit criteria had not been developed for completing the review forms, and that by the very nature of the cases, interpretation could and did vary between team members and across the teams Statewide. Even for a single team member, the frame of reference can change over time, yielding more (or less) stringent assessments. Only one State, however, has undertaken measures to systematically increase the reliability of the review process. In this State, considerable efforts have been made to standardize items and to delete or change items that lend themselves to widely

divergent interpretations. This State has also conducted reliability studies pertaining to the review process.

Most respondents in the five States visited indicated that explicit criteria which were meaningful and practical were crucial to increasing the reliability of the review process. Most also stressed the necessity of more training to increase reliability.

Respondents in several States also cited problems with reliability among States. In this connection, it was felt that a greater Federal effort was needed to standardize the review forms across the States and to produce uniform criteria for administering the forms.

How Much Clout?

There were somewhat different perceptions among the State respondents pertaining to how much control the Medicaid agency could exercise over the facilities. While administrators in several States felt that they could apply pressure on the facilities by withholding Medicaid funds, it appears that this practice is rarely if ever carried out. Several other States felt that they could exercise no real control over the facilities because of the procedural problems actually associated with withholding Medicaid funds. Most of the States cited problems in carrying out the correction process in cases where a recommended change in level of placement was opposed by the resident's family.

While most of the State respondents felt they needed more "teeth" to back up the review process, several felt that their primary job was to motivate facilities to increase their efforts on behalf of specific residents. In these States, the major issue was not how much clout they could exercise, but how much assistance they could offer. It should be noted in this regard that providing information and assistance to facility personnel has the potential for improving the review process as well as the program, since the ability to conduct an effective external assessment is largely dependent on the cooperation of the facility personnel (e.g., in making records available in a maximally useful format). Assisting the facilities - and gaining assistance from them - would therefore

appear to be a reciprocal process, of benefit to the IPR teams, the facilities, and, ultimately, the residents.

Time Constraints

As noted earlier, the time for each resident review ranges from ten to sixty-five minutes. In all of our personal interviews, respondents indicated that there was insufficient time to become personally conversant with the needs of each individual resident. Since most of the allocated time is necessarily devoted to examining the voluminous records which are generally maintained on each resident, the amount of time remaining for direct observation was always minimal. As a consequence, reviewers found that they must rely heavily on the record and on facility personnel for needed information. The brief observations do serve a valuable purpose in permitting reviewers to spot blatant abuses and to gain a sense of resident satisfaction, but they are felt to be too brief to permit observation of the more subtle factors.

Judged Effectiveness

Respondents across all the States visited felt that the review process had increased the amount and quality of documentation at the facilities, and most felt that the professional review process has contributed to improvements in the quality of resident care being provided to residents. Most respondents felt the process is particularly effective in facilities which required a great deal of upgrading. In facilities which were already doing a "good job," the effects of the review process are reportedly less obvious.

In addition to the impact of the review process on resident documentation and quality of care, a number of respondents indicated that the review process has also improved discharge planning. Further, a number of respondents mentioned that the professional reviews have acted to focus attention on the needs of the mentally retarded and the need for more ICF/MR facilities.

III. QUALITY OF CARE

This chapter explores several of the substantive (content) issues involved in reviewing and assessing the quality of care provided to individual residents in ICF's/MR. It includes a brief summary of the regulations, a consideration of the issues involved in making an IPR assessment, and a series of suggested criteria and indicators for use in the review process.

SUMMARY OF REGULATIONS

The basic components of service which must be provided to mentally retarded residents in ICF/MR facilities are spelled out by the regulations (45 CFR 249.13). These regulations are divided into three primary sections:

Section A covers administrative policies;

Section B includes a detailed description of the elements which must be present to ensure that resident living conditions are "normalized;" i.e., that they are as close as possible to the norms and patterns of the mainstream of society; and

Section C specifies the components which are required to implement a plan of active treatment; i.e., to ensure that the physical, social, emotional and cognitive needs of each resident will be met, including:

Evaluation of the needs and potential of each individual resident;

Development of "an individualized habilitation program to meet identified needs," and

Implementation of the habilitation program

through the provision of the specified professional programs and services.

Specific standards are set forth for each component, and these, collectively constitute the regulatory definition of the quality of care which must be provided by an ICF/MR.

ISSUES IN IPR ASSESSMENT OF QUALITY

There are three primary questions involved in the IPR assessment of Quality of Care:

First: What components of quality are to be explored by the IPR team?

Second: On what basis does the IPR team determine that care provided to residents is "quality" care? and,

Third: What tools might be of assistance to the IPR team in making this assessment? Each of these questions will be discussed in the sections which follow.

COMPONENTS OF QUALITY

As noted in the Introduction, the IPR team's responsibility is limited to assessing whether or not the needs of each individual resident are being met. The IPR process is not directed primarily toward enforcement of the regulations. It is instead, an application of the concepts of quality, which are inherent in the regulations, to the assessment of care received by each individual resident.

Since the IPR process is not "tied" to verifying the facility's compliance with the regulations,* there is some flexibility in identifying the issues which are relevant to the needs of individuals. A specific illustration may help to clarify this important point.

For example, there is a specification, under the Food and Nutrition Service, that menus shall be written in advance. Determining whether facilities are in compliance with this regulation is part of the surveyor's

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* This is the surveyor's task.

responsibility. It is not, however, an issue for the IPR team (unless there should happen to be a situation in which this is relevant to the needs of a particular resident).

On the other hand, the specification that food shall be served "with appropriate utensils" is an issue with very specific relevance to differences among individual residents--the knife and fork which are fully appropriate to the independent eater are inappropriate for the profoundly retarded individual who is physically unable to use any self-feeding devise. Therefore, the IPR team may choose to assess the appropriateness of self-feeding devices if it identifies self-feeding as a priority training need for the retarded indivdual.

BASIS FOR DETERMINING QUALITY

Defining the components of quality that are relevant to resident needs is a WHAT issue. Once that is resolved, we need to address the question of HOW. How does the reviewer determines that the care provided is "quality" care? How does he/she decide that a particular component of care is "adequate" or "appropriate"?

The answer to this question is generally phrased in terms of conformity with "accepted professional standards and practices"; i.e., it is assumed that the team can make these decisions on the basis of professional judgment. The difficulty, however, is that, given the present state of the art, knowledgeable professionals can and do differ in their judgments. For example, there is general professional agreement on the desirability of providing a normalized daily rhythm, but there is much more difficulty in defining whether wearing pajamas to breakfast is "normal". Similary, everyone agrees on the importance of self-help, but some reviewers may well react adversely to the messily-made beds which are a product of the residents' bed-making efforts.

Substantiation for the contention that professional judgments differ comes from a variety of sources. First, many facility and agency personnel noted disagreement between surveyors and IPR teams in their assessments of, and recommendations for, the same

facility. Second, a special study of the reliability of assessments between IPR teams was conducted in Minnesota, and a number of discrepancies were identified, particularly in the area of recommendations for improvement. Both of these are instances of inter-rater reliability problems that could be addressed on a within-State basis through the development of a common set of terms and intensive training.

In addition, Pacific Consultants staff directly observed the IPR process in four different States, and we noted major differences in the estimates of quality between States, with professional expectations significantly colored by the typical level of service delived within each of the States. Development of a national approach will be required to deal with this aspect of the reliability issue.

If we are interested in achieving a degree of consistency in IPR assessments, within and between States, then we need to consider what might be done to guide professional judgment. While it is apparent that no universal "rules" can be written to cover every aspect of the complex process, there is clearly a need to develop approaches and tools which will contribute to increasing the reliability of the assessments.

TOOLS TO AID IN ASSESSING QUALITY

There are two major tools which could contribute to standardization in assessing the quality of care: First, operationalized criteria which provide an agreed-upon basis for making professional judgments; and second, instruments (assessment forms) which delineate potential areas for investigation and which specify the components to be emphasized.

(1) Criteria--During the course of our site visits, numerous IPR team members and coordinators expressed a strong desire for interpretive guidelines (and/or criteria) to suppliement and clarify the regulations. The point was also made by many respondents that the same criteria must be utilized by both IPR and survey teams, since these processes represent "two sides of the same coin."

The subject of criteria was also extensively discussed at the national IPR conference. It was frequently pointed out that the regulations are replete with such judgmental terms as "adequate" and "appropriate", and there was general agreement that additional guidance is needed to define these phrases in operational terms. There was not, however, sufficient time at the conference to resolve the many issues involved in the development and application of criteria. It was therefore recommended that a representative Task Force be developed to explore this issue further.

We concur with the recommendation that additional attention be devoted to thes area. The criteria and indicators included in the next section of this manual are therefore offered as preliminary, suggestive approaches which may be useful in beginning the process of criteria formulation.

(2) Instruments--Assuming that reasonable agreement is ultimately reached with regard to the criteria and indicators to be used in assessing the quality of resident care, the question remains: How will these be implemented?

The major tool in the IPR process is the instrument used for recording information on individual residents.* The nature of this instrument is important in three ways:

First, the content of the review form reflects the thinking of the developers about the elements which comprise quality care. For example, one State's form may include a number of items on the personal financial record of each resident, and another may have no items on this component. Clearly, the elements included in the review is different in these two States.

Second, it structures the focus of the review. Thus, two States may both include a specific element, but one may have many more, or more complex, items than the other. For example, one State's form may refer

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* As noted in the Section on the IPR process, States have developed their own assessment forms, generally adopting them from the forms used for Medical Review or IPR in regular ICF's.

only to the presence or absence of an annual physical examination; in this case, the reviewer need only verify that the document is in the record. Another State's form may require information on the "completeness" of the physicians's report, as well as its presence. In this case, the reviewer will need to examine the record for completeness and make a judgment about its appropriateness. Clearly, more emphasis is focussed on the physician's role in the second State than in the first. Thus, the IPR focus is largely a function of the number and depth of the items contained in the assessment form, since these factors determine the amount of time and attention devoted to the review of a particular element.

Third, the form of the instrument (e.g., checklist or narrative) has important implications for the IPR process.

To summarize, the assessment of quality is largely a function of the number, the content, and the form of the items contained within the assessment instrument. For this reason, it is imperative to make conscious decisions about the content and focus of the quality assessment and to incorporate these decisions in the formulation of items to be included in the assessment instrument.

There was extensive discussion of the assessment form at the IPR conference. All participants recognized the importance of this form in structuring the review process. There were, however, some differences of opinion about the potential utility of a nationally-developed form. Most participants felt that States needed to continue to develop their own forms to reflect their special needs and conditions. In addition, many favored development of a national prototype (model), and/or a sharing of other States' instruments, for use in developing their own forms.

In the absence of a national prototype, we are appending several State forms which may serve as useful samples or illustrations. Forms from Minnesota, Utah, and Rhode Island were selected because they contain elements with particular relevance for the mentally retarded population.

PRELIMINARY CRITERIA AND INDICATORS FOR ASSESSING THE QUALITY OF CARE

There are three major areas in which criteria need to be developed, based on the regulations for ICF's/MR. These are:

- The assessment of the resident evaluation performed by the interdisciplinary team
- Assessment of the program which has been developed, and is being implemented, to meet the resident's needs
- Assessment of the efforts directed toward "normalization"

The following presents tentative criteria and indicators for each of these areas. It is important to note that these criteria do not involve any new formulations or requirements for facilities. They are, instead, operational re-statements and applications of the concepts contained in the regulations. As such, they may serve to illustrate the possible utility of criteria as an aid to professional judgment, in the course of the review process.

ASSESSING THE EVALUATIONS

The first step in assessing the quality of care is to determine the adequacy of the initial evaluation of the resident made by the interdisciplinary team, since service delivery must always be linked to the actual condition and capabilities of the individual recipient of that service.

The regulation pertaining to this area specifies that each individual must have a comprehensive evaluation, covering physical, emotional, social and cognitive factors, conducted by an appropriately constituted interdisciplinary team. Further, the evaluation must be reviewed and updated within one month, a prognosis must be developed that can be used for programming (and placement), and a written interpretation of the evaluation, in action terms, must be prepared and made available to specified staff.

Assessment criteria and indicators relevant to this area might include:

Criterion:

The evaluation covers all specified component areas--physical, emotional, social, and cognitive-- including both current status and potential for improvement in each area.

Indicator:

Each evaluation report contains information on current status and potential for improvement, in all component areas.

Criterion:

The evaluation is based upon shared input from all appropriate professional disciplines.

Indicator:

A complete description of the resident, his condition and needs would constitute acceptable evidence that the separate evaluations had been shared.

Indicator:

Direct observation of an interdisciplinary conference by an IPR team member would provide information about the breadth of representation and the sharing process.

Criterion:

Specification of evaluation findings for all components in action terms; i.e., in terms which contribute directly to the development of a plan for training and habilitation.

Indicator:

The cognitive portion of the assessment specifies the particular cognitive tasks which the resident can and cannot perform--in addition to an I.Q. score. E.g.: "is able to follow simple verbal instructions," "can differentiate day and night," etc.

Indicator:

The physical evaluation includes specific behavioral descriptions of ambulation, movement, and activities of daily living, in addition to medical diagnoses;

Indicator:

Emotional and social functioning are characterized in terms of particular behaviors.

Indicator:

In relation to each domain, there is both an assessment of capability and an indication that the resident's potential for growth has been addressed. Any notation of "no potential" would be cause for concern.

Criterion:

The evaluation information has been communicated to caretaker staff.

Indicator:

Caretakers can describe their duties with residents, the activities which they perform with the resident, and the results they expect of the resident. (This information will show knowledge of the program goals and training objectives for the resident.)

The interdiciplinary evaluation is of major importance since it provides the basis for delineating training objectives and developing a plan of care for each resident. The IPR team will then use the facility's training objectives and plan of care as the basis for observing the actual delivery of services and the quality (and appropriateness) of services given to each of the residents.

ASSESSING THE ACTIVE TREATMENT PROGRAM

The regulations identify eleven professional programs and services which must be provided to meet the needs of mentally retarded residents.

In contrast to the specifications for treatment in SNF's and regular ICF's, the emphasis here is very strongly on training and habilitation.* Thus, a special training and habilitation service is mandated, and training components are specified in relation to many of the other treatment areas (e.g., under nursing services, there must be training in habits of personal hygiene, family life and sex education; physical and occupational therapy are to include training in activities of daily living, etc.) In assessing the quality of active treatment, therefore, emphasis should be placed upon the training and habilitation services provided to each resident.

Suggested criteria and indicators of quality of care for four of the eleven mandated active treatment programs might include:

(1) Dental

Criterion:

Absence of dental problems which inhibit eating capability or cause discomfort.

Indicator:

Recorded notes indicate that needed dental work has been performed.

Criterion:

Resident is caring for his/her own teeth to the extent possible.

Indicator:

Observation of residents using toothbrushes. Progress notes on training in care of teeth.

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* Obviously, there remains the basic concern for the safety, health and cleanliness of each individual resident. Instances of neglect or insufficient primary care (as evidenced by decubitus ulcers, malnutrition, or lack of cleanliness) are cause for concern, and these must be identified and fully documented by the reviewer. We are not, however, focussing attention on this area, since we presume that this is a "given."

(2) Training and Habilitation

Criterion:

There is a detailed treatment and habilitation plan for each individual resident which is current (i.e., developed within the previous year), complete (i.e., covers all components--physical, emotional, social, cognitive), and objective-oriented (i.e., specific objectives are established on the basis of the behavioral evaluation and a time frame for achievement is included).

Indicator:

Written behavioral objectives are explicitly stated in terms of the level of expected performance and the timelines for achievement. (For example, where the initial examination has shown that the resident is able to unbutton, but not re-button, his/her clothing, there should be a specific plan for providing instruction in this particular skill during a specified time period. Other specific training objectives in the area of dressing might include putting shoes on the correct feet, zipping front zippers, etc. A goal of "improving dressing skills" would be too broad to serve as a working guide for training activities.)

Criterion:

Staff who work directly with the resident know and are implementing the training and habilitation plan.

Indicator:

Staff can accurately describe the objectives and training program for that resident. (For example, caretakers specify "buttoning" as a task being taught.)*

Indicator:

Progress notes indicate the amount of progress being made toward each objective.*

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* It is also suggested that the reviewer watch for inconsistant reports, verbally or in progress notes, among different caretakers.

Indicator:

Observations indicate that appropriate training activities are occurring. (To continue the example of the objective of buttoning clothes, the reviewer might observe whether there is a buttoning board among the resident's possessions or even whether the resident's shirt is mis-buttoned.*)

Criterion:

Evidence of an appropriate level of activity for each resident. (Life should be rich and full, and unproductive idle time should be kept to a minimum--in no case, exceeding more than three hours a day. On the other hand, it is important that resident's lives not be over-programmed to the extent that there is never an opportunity to explore or develop individualized interests. While this is a subtle and difficult distinction, it might be useful to attempt to distinguish between "unprogrammed, but productive leisure activity" and "idle time.")

Indicator:

A regularly-scheduled program of diverse activities is established, and implemented, for each individual resident.

Indicator:

There are special activities (e.g., field trips) beyond those mandated under the legislation.

Indicator:

"Hobby" materials (e.g., board games, needlework supplies, building blocks, a piano--in addition to the omni-present television set) are available in the day room.

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* In this connection, it is important to mention that, while tidiness is desirable, some unkempt appearances may result from self-help by residents, and this may well be a positive, rather than a negative indicator, in the case of a particular resident.

Criterion:

All prescribed therapies (PT, OT, speech therapy, etc.) are being provided as evidenced by progress notes and/or observation.

The area of habilitation and training is most difficult for profoundly impaired individuals. Here, the reviewer should look for indications that touching, music, talk, and other forms of stimulation are consciously planned and that there are progress notes on the responses elicited.

3) Food and Nutrition

Criterion:

Each resident is being trained and encouraged in self-help eating skills.

Indicators:

Progress note and direct observation show that:

Residents who are capable of independent eating are provided with utensils and opportunities to serve themselves;

Residents who cannot manage forks and knives are assisted in food cutting and are provided with food guards and spoons so that they may self-feed to the fullest extent possible; and

Feeding by staff is limited to those residents who cannot take part in any aspect of feeding.

4) Medical Services

As stipulated in various regulations, physicians are responsible for:

A complete annual physical exam, with specified components;

Provision of all needed medical treatment;

Participation in the development of the active treatment plan;

Re-affirmation that continued placement in an ICF/MR is required--at 60-day intervals; and

Review of all medications--at 90-day intervals.

Since a sizable proportion of mentally retarded residents are as physically healthy as normal persons, the nature of the physician's involvement will logically be directed more toward the maintenance of health than toward the treatment of acute illness. A key element of health maintenance is the complete annual physical exam. Further, the physician is required to play an active role in the development of the active treatment plan, including prescribing necessary therapies. In order for the physician to fulfill this function, it is essential that he/she have an individualized knowledge of the condition, prognosis and needs of each resident. Finally, the role of medications is of particular importance in the medical treatment of mentally retarded persons--for controlling seizures and managing behavior-as well as for treating specific illnesses. As a consequence, the prescription of appropriate medications, and the adequate and timely monitoring of these medications is very important. Here, again, the issue of individualization is paramount. Criteria appropriate to each of these areas might include:

Criterion:

Each resident has had a complete physical examination within the previous year, including:

Examination of hearing and vision, and the prescription of glasses or hearing aids, as appropriate

All necessary laboratory screening

Immunizations

Indicator:

Medical records indicate that a complete physcial examination, including all necessary components, has been performed within the previous year.

Criterion:

The physician has individualized knowledge of each resident.

Indicator:

At least some of the physician's notes demonstrate a particularized awareness of the resident as a unique individual.
(Note: While it is anticipated that the extensive and frequent reporting required of the physician may result in relatively prefunctory recording, it is essential that even brief notations be individualized. In one situation, described to us by an IPR team, all medical progress notes were framed in identical language--i.e., "_____'s condition is stable"; clearly, this type of notation in multiple residents' records would constitute a negative indicator in the area of individualization.)

Indicator:

Medical notes are consistent with the observed condition of the individual resident.

Indicator:

Prescribed therapies are linked to individually-diagnosed needs.

Criterion:

Prescribed medications are appropriate.

Indicator:

Medications have been prescribed on the basis of individually diagnosed needs.
(Note: An example of the lack of such individualization was cited by one IPR team; specifically, all adult females in the facility were being given contraceptive pills, apparently without regard for their individual conditions or level of sexual activity.)

Criterion:

Monitoring of medications is timely and adequate.

Indicator:

The physician's records show that medications have been reviewed (and renewed or discontinued), at least quarterly.

ASSESSING NORMALIZATION

The third area in which criteria and indicators may be useful for IPR teams is in the extent to which a normalized environment is provided for residents.

The regulations include a detailed description of the elements which must be present ensure that resident living conditions correspond, as closely as possible, to the norms and patterns of the mainstream of society. While there is some question as to whether it is possible to achieve this goal within an institutional setting, it is clearly intended that maximum effort be directed toward approximating a normal living condition.

Suggested criteria and indicators of normalized living might include:

Criterion:

The living schedules are individualized and responsive to resident's conditions and needs rather than to the convenience of staff.

Indicator:

There are different bedtimes for different residents, based on age and functioning level.

Indicator:

There are opportunities for recreational activities in the evenings and on weekends.

Criterion:

There is a personalized living space, appropriate to the age and condition of each resident.

Indicator:

Personal combs, brushes, and mirrors are available for all residents who are able to groom themselves.

Indicator:

Some "constructive clutter," reflecting personal interests; e.g.,(resident's art work, magazines, games and toys, which show signs of use) is evident in resident's bedroom area.

Criterion:

There is access to goods and services within the community, to the fullest extent possible.

Indicators:

Residents go on outings, including situations in which they mingle with community residents (e.g., church, bowling, shopping, etc.)

Residents who are able go out for some services (e.g., dental work).

Criterion:

There are opportunities for residents to make their own choices, insofar as possible, including the freedom to make some mistakes.
(Note: It is no more reasonable to expect perfect behavior from retarded persons than it is to expect such behavior from "normal" persons.)

Indicator:

There is a vending machine or other access to self-selected snacks.

Indicator:

Cottage doors are unlocked and there is free access to outdoor space (unless specifically contraindicated).

Indicator:

There are many choices available for leisure activities (persistent group "herding" is avoided).

Indicator:

There are opportunities for cross-unit or cross-section grouping for leisure games and gatherings.

Criterion:

Individually-appropriate social interaction is encouraged.

Indicator:

Caretakers actively work to facilitate the development of relationships between residents, including toleration of hostile (verbal) interactions* as well as encouragement of activities requiring more than one participant.

Indicator:

There are opportunities for male and female residents to get acquainted.

Criterion:

Caretaking staff have positive attitudes toward residents.

Indicators:

Caretakers talk with, rather than at, residents;

Caretakers listen to residents;

Caretakers are able to interpret the speech of hard-to-understand residents;

Communication between staff and residents is warm and friendly, as shown by smiling, touching, eye contact, etc.

Criterion:

Facility staff respect the rights and dignity of each individual.

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* One Conference Workshop voiced concern about coping with residents who are physically as well as verbally abusive. Clearly, this situation would not fall under our meaning of "appropriate social interaction." While there was no consensus on how such behavior should be handled, participants mentioned the use of medication, behavior modification techniques, and, particularly, an increase in staff and programs as methods of dealing with aggressive behavior.

Indicator:

There are doors on bathrooms.

Indicator:

Caretakers avoid talking about residents as though they weren't present, and

Caretakers do not refer to adults as "kids."

In concluding this section, it must be emphasized that the foregoing criteria and indicators are neither final nor inclusive. Only four of the eleven service areas have been addressed, and, even in these areas, the listing of possible criteria and indicators are suggestive, rather than exhaustive. We hope that they will serve to illustrate an approach which might be used for developing criteria--that they will help to begin the process of criteria formulation.

Finally, a few words must be said about training. In this chapter, we have focussed on the development of criteria and assessment forms as working tools. These tools are of vital importance if there is to be consistency in the assessment process. Even more important, perhaps, is the role of training, since tools are only as useful as the user's knowledge of them.

As shown in the preceding chapter, specialized training for IPR teams, especially in relation to ICF's/MR, is limited; and there was virtually unanimous agreement at the IPR conference that additional training is both needed and wanted. A national training program, comparable to that offered for surveyors, was recommended, and this would certainly appear to be a priority need.

IV. DETERMINATION OF APPROPRIATENESS OF PLACEMENT

As stated in the IPR draft guidelines: "A secondary goal of Independent Professional Review is to match the kinds and degrees of physician, nursing, and personal services actually needed by the patients with facilities most able to render such care, i.e., to make certain that the kind of care offered by a Title XIX certified Intermediate Care Facility is, in fact, necessary to meet the current medical, nursing, personal or psychiatric needs of individual residents; and if not, to recommend and initiate action for transfer of such residents to alternate and more appropriate arrangements."

There are a number of implications which flow from this statement. First, determining the appropriateness of a specific facility for a particular individual depends, to a very large measure, on an assessment of the condition, potential and needs of that individual. Secondly, a definition of the "kind of care offered" by each ICF/MR is imperative if judgments are to be made as to the appropriateness of that care for a given resident. Third, the availability of "alternate and more appropriate arrangements" is clearly a key factor in influencing the decision to recommend (or not to recommend) transfer. And, finally, it is necessary to look at actual practice in order to determine to what extent this aspect of the IPR process is treated as "secondary." Each of these issues will be briefly explored in the sections which follow.

ASSESSMENT OF RESIDENT'S CONDITION AND NEEDS

Since mental retardation is a global term, encompassing an extremely broad array of functional levels, the initial point of departure in ascertaining the needs of a particular resident is the determination of that resident's condition. A number of specific evaluation

components were identified in the section on Quality of Care, including the need for behaviorally-structured descriptions of the resident's physical, social, emotional, and cognitive capabilities and potential. This information is also the initial basis for considering the appropriateness of placement. Greater emphasis must, however, be placed on those specific elements which relate to the level of care required; for example, behavior problems requiring supervision beyond that which would normally be provided in relation to the identified cognitive level; and physical or sensory problems requiring increased (or total) care. Taking all these facets into consideration, it is possible to structure a series of functional levels which relate directly to the amount of care needed. One such scheme has been proposed by Minnesota as follows:

(1) ICF-MR TRANSITIONAL LEVEL

- Resident is adolescent or adult who is mildly or moderately retarded
- Resident needs minimal protection and security

(2) ICF-MR INTENSIVE LEVEL

- Any resident who:
  a. is non-ambulatory
  b. has serious chronic or health problems
  c. has serious emotional or behavioral disorders
  d. has a sensory disability
- Resident needs moderate protection and security

(3) ICF-MR CONCENTRATED LEVEL

- Any resident who:
  a. inflicts serious injury to self or others
  b. is a security risk
  c. has multiple sensory disabilities

- Resident needs maximum protection or security

(4) ICF-MR DEVELOPMENTAL LEVEL

- Resident is child, pre-adolescent or adult who is severely or profoundly retarded

- Resident needs maximum protection or security

(5) ICF-MR UNDIFFERENTIATED LEVEL

- To be used for ICF-MR level of care if no sub-levels are defined

The material shown above has been abstracted from the instructions accompanying the IPR form to portray only the resident descriptors. As developed by Minnesota, each level also contains information on staffing ratios and professional emphasis, since the levels were designed to be descriptive of the sub-levels of care provided within ICF/MR facilities (as well as the functional and need levels of residents who are appropriately served by the various facility sub-levels). At the time of this writing, the sub-classification scheme was being tested and no decision had been made with reference to its continued use.

In addition to the delineated sub-levels of care, the Minnesota IPR form includes information on the resident's age, general condition, on-set and severity of retardation, disabilities and potential for restoration.* All of these elements are relevant to making a determination as to the appropriateness of the level of care being provided to each individual resident.

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* The Minnesota form contains more comprehensive diagnostic information than any of the other forms which we have seen, and a great deal of attention in this State has been directed toward ascertaining levels of functioning and care. Perhaps because of this focus, interviewees in Minnesota were particularly desirous of more explicit criteria.

Considerations in Defining Appropriateness

Integrating these elements into specific, operational criteria--which will have applicability throughout the nation--will require a great deal of additional effort.

At present, the only Federal guidance which is available is the statement that "...people may be placed in Intermediate Care Facilities because of a mental or physical condition necessitating supervised health care below the level of skilled care, but above room and board."* The specific interpretation is again left to the professional judgment of the reviewer.

While the parameters have been generally established, it is, nonetheless, frequently difficult to make judgments about particular individuals. For example, questions have been raised as to whether totally disabled, very profoundly retarded persons ought not be considered candidates for skilled nursing care. In this instance, it appears that the need is for total care (which can be provided by non-nursing personnel) rather than for skilled nursing care, although there may very well be individual situations where skilled care is required. A number of other examples were observed in the course of the on-site observations. In one State, the review team was concerned whether an older, emotionally disturbed, retarded individual should be recommended for transfer since his condition had declined to the point where he could no longer utilize the habilitative components of the program. In another State, concern was expressed about a mildly retarded young man whose major problem was a potential for socially unacceptable behavior. In yet another case, we wondered whether a well-behaved, physically healthy, quite able young adult (who worked regularly in a sheltered workshop in the community) was appropriately placed in an ICF/MR.

It is likely that generally applicable criteria will be extremely difficult to formulate, since the answers depend, at least in part, on the nature and perceived purpose of the ICF/MR program in any given State. Thus, consideration of existing levels of care is necessary

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* From the draft IPR Guidelines.

in order to meaningfully examine the convergence of a patient's needs with the programs or facilities available to meet them.

LEVELS AND TYPES OF CARE

Definition of ICF/MR Facilities

Title XIX defines an Intermediate Care Facility as an institution providing "on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but because of their mental or physical condition require care and services (above the level of room and board)..."*

Intermediate Care Facilities for the Mentally Retarded are a sub-set of Intermediate Care Facilities. As such, they are intended to provide long-term care to mentally retarded persons whose needs correspond with the definition provided earlier; i.e., above the level of room and board. In addition, they must provide active treatment to assist "each of their residents to achieve or maintain optimal function in all dimensions of physical, social and psychosocial health."** More specifically, they must comply (or be moving toward compliance) with the standards set forth in the regulations (45 CFR 249.13). Any long term care facility serving the mentally retarded which meets these standards may be certified as an ICF/MR. Because of the breadth of this definition, it is apparent that the ICF/MR concept may be applied to a large array of very different facilities.

In practice, most of the facilities which are currently certified as ICF's/MR are State-operated institutions for the mentally retarded, or specific portions (cottages or units) of State institutions. There is, however, a trend (more marked in some States than in others) toward certifying a variety of privately-owned, community-based facilities which were already function-

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* Section 1905(c) of Title XIX.

** From Guidelines.

ing as regular ICF's and which were serving a sizeable proportion of mentally retarded. In a few instances, much smaller (less than fifteen bed) facilities have been certified as ICF's/MR. These include existing and newly created group homes, generally clustered under a single administration to facilitate the provision of mandated services.*

Variations in Kinds of Care

The "kinds of care" provided by these various facilities (and the kinds of residents who are "appropriately" served by them) differ markedly. Differences in kinds of care are based on the history of the facilities and the States in which they function, the perspectives of the various States and communities, and the nature of the facilities themselves. Thus, for example, the State-operated facilities in one State have served almost exclusively adults, and this pattern has not altered as a result of certification. As a consequence, a mentally retarded youngster being served in an institutional setting would be considered appropriately placed in one State and inappropriately placed in the other.

Variations in perspective are even more diverse. In one State, the upgraded institutions which have been certified as ICF's/MR are perceived as providing a high quality of care, relative to the other options available in the State. In this State, therefore, the large institutions are generally considered appropriate for serving residents with relatively high potential for developmental growth; residents are recommended for transfer out (to regular ICF's or other, more custodial care) when it is felt that they can no longer make significant progress. In another State, every effort is made to avoid caring for the mentally retarded in large institutional settings. In this State, residents with virtually any potential

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* The certification of very small facilities is made possible by the provision that specialized needed services may be purchased, on a contract basis, from outside sources. Without this provision, small facilities would be unable to meet the requirements since it would be impossible to support a full-time doctor, nurse, PT, OT or other specialist in a facility serving a handful of residents.

are transferred to community-based ICF/MR facilities and those with relatively high potential are recommended for transfer out to independent living facilities insofar as possible; as a consequence, the population remaining in institutional care in this State is (or soon will be) virtually limited to the most profoundly retarded.

Spectrum of Services

It is apparent from the foregoing that the designation of ICF/MR can encompass a wide spectrum of services, with varying levels of care for the mentally retarded provided by different facilities (or portions of facilities) within the ICF/MR system. Thus, a single institution may have a large number of different cottages, each of which is structured to serve a different population--based on age, severity of retardation, potential for restoration, physical and sensory disabilities and other factors. Similarly, as previously noted, it is possible to certify a wide range of very different types of facilities as ICF's/MR--State institutions, large community-based facilities, and small homes--and each of these may be structured to serve a very different population.

Given the diversity within the mentally retarded population, it would clearly be desirable to structure every State's ICF/MR program so as to provide the maximum range of allowable service levels (i.e., below the level of SNF and above the level of room and board). Where a broad spectrum of service exists within a State's ICF/MR system, most issues of appropriateness of placement can be resolved internal to the system--i.e., residents may be transferred up or down (in terms of level of care) while still being served by an ICF/MR. In these instances, residents need be transferred out of the system only at the extremes--that is, where medical problems become clearly dominant and the need for skilled nursing is apparent or where the individual is functioning so well that there is no longer a need for 24-hour-a-day supervision. Where the spectrum of services within the ICF/MR system is limited, the necessity for transfers out of the system is greatly increased. For example, in a State which serves only minors within the State institutions and which has only a very small number of community-based ICF/MR beds,

there is little alternative to placing retarded adults in regular ICF's.

This raises the question as to whether a regular ICF is to be considered an equivalent, a higher, or a lower level of care, and, further, whether the placement of mentally retarded persons in regular ICF's is appropriate. There appears to be considerable difference of opinion on this issue. A number of interviewees expressed the belief that a regular ICF is a lower level of care (since it is generally less costly); and that it is appropriate for some mentally retarded persons, particularly if they are over fifty years of age or if the onset of mental retardation occurred after age eighteen. Others expressed the belief that all those who have a primary diagnosis of mental retardation belong in ICF/MR facilities. One possible approach, recommended at the Federal level, is the dual certification of ICF's, so they include both regular and MR sections. This would seem a promising possibility, since it would reduce the necessity for transferring mentally retarded residents who have made a good adjustment in a regular ICF. It will not be accomplished without a strong State commitment, however, since many regular ICF's are resistant to adding the components required to achieve certification as an ICF/MR.

AVAILABILITY OF ALTERNATIVES

Decisions about appropriateness of placement are influenced by the availability of more suitable alternatives. As suggested in the preceding section, some States provide more options within the ICF/MR service continuum. Similarly, some States have available more options outside the framework of intermediate care, particularly in the area of independent living. Where these increased options exist, the impetus to identify individuals with potential for independent living is greatly increased. Where few options exist, the converse is true. One State, for example, feels constrained to serve high level retardates within the institutional setting because of the poor treatment accorded these individuals when they are placed in community settings; this in turn derives from general community attitudes and the consequent unavailability of support services (such as trainable classes and sheltered workshops) within

these communities.*

In this case, there is little incentive for review teams to attempt to identify individuals who might appropriately be served within the community. It is strongly suggested, however, that the appropriate level of care be specified by the reviewer--whether or not options exist--first, because this is the intent of the legislation and, second, because this may provide a substantive basis for subsequent planning (and community education, if need be) to secure/create alternative resources. Where alternative placement is appropriate and no alternative facilities exist, documentation of the lack of alternatives is sufficient to justify retention of the resident in the facility.

IMPORTANCE OF DETERMINING APPROPRIATENESS

Finally, there is a question as to the relative importance which is attached to a determination of appropriateness by IPR reviewers in the various States. Our impression, based on interviews, observations, and an examination of IPR forms, is that this issue is given high priority in many States. An interviewee in one State indicated that Federal inquiries about transfers are more dominant than inquiries about quality of care and that this tends to focus attention on this area. Others have suggested that reduction of the level of care is a primary concern, because it is linked to reduction in costs. Another factor which tends to focus attention on this area is the linkage between IPR and Utilization Review in some States; i.e., where the IPR team also fulfills the Utilization Review function, there is a tendency to place greater emphasis on appropriateness of placement than upon the upgrading of services. While there is considerable force to this position, the basic intent of the

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* In general, where there is strong community interest in Mental Retardation, especially a strong Association for Retarded Citizens, more support services are provided with Title XX funds and, as a consequence, both the families and the communities are more willing to house their mentally retarded.

regulations is to improve the quality of care in ICF/MR facilities. Monetary (and other) benefits associated with recommendations for alternative placement must therefore be considered secondary.

APPENDIX A

MINNESOTA

INDIVIDUAL ASSESSMENT

FORM

1977 Revision

QUALITY ASSURANCE AND REVIEW PROGRAM
MINNESOTA DEPARTMENT OF HEALTH

1977

[1]

INDIVIDUAL REVIEW FORM

PART I GENERAL INFORMATION

Label - Facility Name
Address
(2,3,4,5)(6)
(Facility & Dist. Codes)

ROOM No. _____

M.A. No. [ ] (9–22)

NAME [ ] (24 last - print, 39)

[ ] (68 first - print, 68) [ ] (69 m.i.) [ ] (70 sex)

LEVEL OF CARE: 1. SNF; 2. ICF; 3. Psych. Hospital; 4. ICF-MR Transitional; 5. ICF-MR Developmental; 6. ICF-MR Intensive; 7. ICF-MR Concentrated; 8. ICF-MR Undifferentiated [ ] (28)

Year Birth [ ] (51)

Mo/Yr Admission [ ] (55–57)

ADMITTED FROM: 1.Home; 2.Hosp; 3. State MI-MR Facility; 4. Other Long Term Care Fac. [ ] (59)

IF PREVIOUSLY IN MENTAL HOSP: 1.State MI-MR Fac.; 2.Other; 3.Unknown [ ] (60)

YR FIRST ADMITTED 19 [ ] (61)

YR LAST DISCHARGED 19 [ ] (63)

RELATIVE: Relationship: 1.Parent; 2.Spouse; 3.Sibling; 4.Child; 5.Other; 6.None [ ] (65)

Living Within 30 Miles: 1. Yes; 2. No [ ] (66)

Frequency of Visits by Relative: 1. 1-7 days; 2. 1-4 weeks; 3. 1-6 months; 4. 6-11 months; 5. 12+ months; 6. Never [ ] (67)

RESPONSIBLE PHYSICIAN [ ] (68 last, 83) [ ] [ ] (84 initials)

PART II MEDICAL CONDITION

[2] (1)

A. MEDICAL DIAGNOSES: print - one each line

	Year Recorded	HICDA Code Do Not Fill In
1. _____	19 [ ] (86)	[ ] (88)
2. _____	19 [ ] (92)	[ ] (94)
3. _____	19 [ ] (98)	[ ] (100)
4. _____	19 [ ] (104)	[ ] (106)
5. _____	19 [ ] (110)	[ ] (112)
6. _____	19 [ ] (116)	[ ] (118)

B. POTENTIAL FOR RESTORATION TO:
a. Independent Living: 1.None/slight; 2.Moderate; 3.Good; 4.No record [ ] (122)
b. To Lower Level Institutional Care: 1.None/slight; 2.Moderate; 3.Good; 4.No record [ ] (123)

C. SUMMARY OF GENERAL CONDITION: 1.Improving; 2.Stable; 3.Unstable; 4.Declining; 5.Terminal; 6.No record [ ] (23)

COMPLETE D&E ONLY IF DIAGNOSED MI OR MR

D. MAJOR MENTAL ILLNESS DIAGNOSIS: PRIOR TO ADMISSION: 1. Yes; 2. No; 3. Unknown [ ] (24)

PSYCHIATRIC EVALUATION RECORDED: 1.Yes; 2.No [ ] (25)

YEAR LAST EVALUATION RECORDED: [ ] (26)

E. MENTAL RETARDATION DIAGNOSIS: ONSET: 1.Infancy; 2.Developmental (<age 18); 3.Age 18-65; 4.Over 65; 5.No record [ ] (20)

SEVERITY: 1.Borderline; 2.Mild; 3.Moderate; 4.Severe; 5.Profound; 6.No record [ ] (21)

PART III INDIVIDUAL ASSESSMENTS (DATA BASE) AND PLANS

Record the Appropriate Number in Col. 1 ONLY: 1.Present; 2.Present/incomplete; 3.Absent; 4.Not apply

	Col. 1	Col. 2
A. MEDICAL SERVICE		
1. Complete medical evaluation including history, physical, diagnoses and rehabilitation potential	[ ] (30)	[ ] (31)
2. Medical plan of care including frequency, duration and purpose for all medications and treatments, and diet	[ ] (32)	[ ] (33)
3. Current psychiatric treatment is coordinated with the medical plan of care	[ ] (34)	[ ] (35)
4. Medical progress evaluations including current condition, reassessment and revision of the treatment plan	[ ] (36)	[ ] (37)
5. Annual interim history and physical	[ ] (38)	[ ] (39)
B. SPEECH ASSESSMENT & APPROPRIATE THERAPY	[ ] (40)	[ ] (41)
C. HEARING ASSESSMENT & APPROPRIATE THERAPY	[ ] (42)	[ ] (43)
D. VISION ASSESSMENT & APPROPRIATE THERAPY	[ ] (44)	[ ] (45)
E. DENTAL ASSESSMENT & APPROPRIATE THERAPY	[ ] (46)	[ ] (47)
F. ASSESSMENT OF PSYCHOSOCIAL BACKGROUND WITH PLANS FOR APPROPRIATE ACTIVITIES AND COUNSELING	[ ] (48)	[ ] (43)
G. INDIVIDUAL/NURSING RECORD: 1. Nursing assessment for care needs	[ ] (50)	[ ] (51)
2. Patient plan of care with short and long term goals	[ ] (52)	[ ] (53)
3. Habilitation Program plan for M.R. (Applies only to M.R. resident)	[ ] (54)	[ ] (55)
4. Discharge potential and plan	[ ] (56)	[ ] (57)
H. LEVEL OF CARE EVALUATION ACCORDING TO SPECIFIC FACILITY CRITERIA	[ ] (58)	[ ] (59)

PART IV INDIVIDUAL DEPENDENCIES AND POTENTIAL FOR RESTORATION *(PR: 1.Slight; 2.Moderate; 3.Good)*

	Depen.	Pot. for Rest.
1. DRESSING: *0.Independent; 1.Help/Supervision to lay out clothes, tie shoes, zippers; 2.Aid of another person; 3.Dressed completely; 4.Never dressed*	80	81
2. GROOMING: *(Care of teeth/dentures, combing hair, shaving, naks up, nail cars) 0.Independent; 1.Slight preparation by someone; 2.Aid in 2 or 3 areas; 3.Aid in all areas*	82	83
3. BATHING: *0.Independent; 1.Supervision only; 2.Aid to get in and out of tub; 3.Aid in washing; 4.Bathed completely*	84	85
4. EATING: *0.Independent; 1.Slight help to cut meat, arrange food; 2.Feeds self with help or supervision of another person; 3.Completely fed; 4.Tube fed*	66	67
5. BED MOBILITY: *0.Independent; 1.Occasional help to sit up; 2.Always helped to sit up; 3.Must be turned and positioned*	86	66
6. TRANSFERRING: *0.Independent; 1.Needs guidance only; 2.Aid of one person; 3.Needs two persons or mechanical device; 4.Bedfast*	76	71
7. WALKING: *0.Independent; 1.Independent with device; 2.Aid of one person; 3.Aid of two persons; 4.Does not walk*	72	73
8. WHEELING: *0.Independent; 1.Help with ramp/elevator; 2.Must be wheeled; 3.Not wheeled: bed or chair fast*	74	75

	Depen.	Pot. for Rest.
9. COMMUNICATION: *0.Normal speech; 1.Speech impairment but can be understood; 2.Non-verbal, written/gestures; 3.Inappropriate content, echolalia, garbled sounds; 4.Does not/will not speak; 5.Language barrier*	78	77
10. HEARING: *0.Normal; 1.Normal with hearing aid; 2.Impairment; 3.Does not hear; 4.Unknown*	78	79
11. VISION: *0.No impairment; 1.Impairment corrected with glasses; 2.Impairment; 3.Blind; 4.Unknown*	86	81
12. ORIENTATION: *0.Oriented; 1.Minor forgetfulness; 2.Partial/intermittent periods of disorientation; 3.Totally disoriented: Does not know time, place, identity; 4.Comatose; 5.Unknown*	62	83
13. BEHAVIOR: *0.No problem; 1.Observation for potential problem behavior; 2.Uncooperative, wanders, withdrawn, crying, hallucinates; 3.Disruptive/runs away; 4.Some of above plus assaultive*	84	85
14. TOILETING: *0.Independent; 1.Needs help to toilet, no incontinence; 2.Occasional accident; 3.Nocturnal incontinence only; 4.Incontinent bladder; 5.Incontinent bowel; 6.Incontinent bowel and bladder or not trained*	86	87
15. SELF PRESERVATION SKILLS: *0.Independent; 1.Minimal supervision; 2.Mentally unable; 3.Physically unable; 4.Both 2 & 3*	88	89

PART V INDIVIDUAL TREATMENT PROGRAMS

A. INDIVIDUAL CARE REQUIREMENTS:

1. MEDICATIONS

a. *1.Number of oral medications* — 90

2.Total number of doses administered daily — 92

b. *1.Number of injectable medications ordered* — 94

2.Average number of injections per week — 95

c. *1.Number of other medications* — 97

2.Average number of applications per day — 99

2. NUMBER OF CLINICAL MONITORING PROCEDURES PER DAY — 101

3. THERAPEUTIC DIET: *1. Yes; 2. No* — 103

4. SPECIAL TREATMENTS:

a. Tube Feeding: *1.Self administration w/o help; 2.Self administration with help; 3.Given by staff* — 104

b. Oxygen and Respiratory Therapy: *1.Self administered; 2.Given 2 or 3 times weekly; 3.Given daily* — 105

c. Tracheotomy Care: *1.Routine care with occasional suctioning; 2.Special care, dressings, frequent daily suctioning* — 106

d. Retention Catheter: *1.Routine care includes changing; 2.Special care, irrigations* — 107

e. Ostomy: *1.Self care; 2.Routine care irrigations by staff; 3.Special care skin problems, teaching self care* — 108

f. Dressings: *(Does not include ace bandage/ted stockings) 1.Simple dressings daily; 2.Large dressings daily; 3.Large dressing or extensive dressing more than twice daily* — 109

g. Skin Care: *1.Special measures to maintain health of skin, foot soaks, heat lamp; 2.Dermatitis, stasis ulcer, abrasions and other lesions; 3.Decubitus ulcer* — 110

h. Rehabilitation Procedures—ROM/Exercise; Ambulation; ADL; Transfers: *1. 1 of above; 2. 2 of above; 3. 3 of above; 4. all of above* — 111

i. Toileting: (Bladder) *1.Routine program of taking to toilet; 2.Written individualized program* — 112

j. Toileting: (Bowel) *1.Routine program: take to toilet/suppository; 2.Written individualized program* — 113

B. SPECIAL PROGRAMS: *(Record appropriate number if individual is in a current program)*

1. Speech Therapy: *1.Programmed by therapist; 2.Plus reinforced by nursing/staff* — 114

2. Physical Therapy: *1.Directed by therapist; 2.Plus reinforced by nursing/staff* — 115

3. Occupational Therapy: *1.Directed by therapist; 2.Plus reinforced by nursing/staff* — 116

4. Social Counseling: *1.Counseling by trained counselor; 2.Plus reinforced by nursing/staff* — 117

5. Psychological Counseling: *1.Counseling by trained counselor (Include behavior therapy); 2.Plus reinforced by nursing/staff* — 118

6. Psychotherapy: *1.Programmed by Psychiatrist; 2.Plus reinforced by nursing/staff* — 119

7. Activity Program: *1.Programmed by the Director; 2.Plus reinforced by nursing/staff* — 120

8. Reality Orientation or Remotivation Program: *1.Current structured program; 2.Plus reinforced by nursing/staff* — 121

9. M.R. Program: *1.Programmed by M.R. specialist; 2.Plus reinforced by staff/nursing* —

3

PART VI REVIEW TEAM SUMMARY AND RECOMMENDATIONS

A. ASSESSMENT INDICATES THAT THIS PERSON NEEDS: [23]
1. *Skilled Care for Restorative Treatment*
2. *Skilled Care for Unstable Disease*
3. *Skilled Care for Special Nursing Treatment Around-the-Clock*
4. *Skilled Care for Complex Management*
5. *Intermediate Care for Maintenance*
6. *ICF-MR*
7. *Psychiatric Care*
8. *Acute Hospital Care*
9. *Independent Living*

B. WOULD A DPW SPECIAL LICENSED PROGRAM BE BENEFICIAL FOR THIS PERSON EITHER HERE OR IN A NEARBY FACILITY? [24]
1.No; 2.Yes M.R.; 3.Yes M.I.; 4.Yes C.D.

C. THE FOLLOWING COMPONENTS OF THE INDIVIDUAL CARE PROGRAM NEED STRENGTHENING: *(X Box)*

1. INDIVIDUAL ASSESSMENT AND PLAN:

a. *Medical Services:*
1. *Complete medical evaluation* [25]
2. *Medical Care Plan* [26]
3. *PRN orders include dosage, frequency, purpose* [27]
4. *Coordinated psychiatric treatment program* [28]
5. *Progress evaluations include current condition, results of treatment, reassessment and revision of treatment plan* [29]
6. *Annual interim history and physical* [30]
7. *Medical consultation* [31]

b. *Speech, Hearing, Vision Assessment:*
Spch. [32] *Hrng.* [33] *Ven.* [34]

c. *Dental Assessment* [35]

d. *Psychosocial Assessment and Plans* [36]

e. *Activity Assessment and Plans* [37]

f. *Nursing/Staff Services:*
1. *Individual assessment for care needs:* [38]

Personal Safety [39] *Skin Care* [43]
Grooming [40] *Physical Mobility* [44]
Oral Hygiene [41] *Personal Possessions* [45]
Nutrition [42] *Privacy* [46]

2. *Patient Care Plan* [47]

3. *Goals: Short* [48] *Long* [49]

4. *Habilitation Program Plan for M.R., M.I., or C.D.* [50]

5. *Discharge Potential and Plan* [51]

2. INDIVIDUAL TREATMENT PROGRAMS: (Part V-A)
a. *Recorded administration of medications, treatments and PRN orders* [52]
b. *Clinical monitoring of medications, treatments and health status* [53]
c. *Bowel and bladder program* [54]
d. *ADL training* [55]

3. INDIVIDUALIZED SPECIAL PROGRAMS: (Part V-B)
a. *Physical therapy* [56]
b. *Occupational therapy* [57]
c. *Social Service counseling:*
Personal [58] *Family* [59]
d. *Psychological counseling* [60]
e. *Individualized activity program:*

Personal Interests	[61]	*1:1 visits*	[65]
Opportunities to go out	[62]	*Intellectual Stimulation*	[66]
Socialization small group	[63]	*Reality Orientation*	[67]
Socialization large group	[64]	*Remotivation*	[68]

f. *Specialist consultation for M.R., M.I., or C.D.* [69]
g. *Normalization/Social Training etc.* [70]
h. *Vocational training* [71]
i. *Educational training* [72]
j. *Behavior modification/therapy* [73]

4. EXPLANATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

_____ R.N. _____ S.W.

_____ M.D. DATE [74][75] [76] 197[78]

APPENDIX B

UTAH

IMR PATIENT REVIEW FORM

DRAFT

STATE OF UTAH
PATIENT CARE PROFILE FORM 15

1. Provider Number ☐☐☐☐☐☐ Client ID ☐☐☐☐☐☐☐☐-☐

Sex ☐

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birthdate ☐☐☐☐☐☐ M M D D Y Y Age ☐☐ Adm. Date ☐☐☐☐☐☐ M M D D Y Y

Race ☐ (1. Caucasian 2. Black 3. Native American 4. Asian American 5. Spanish Surname 6. Other 7. Unknown)

Title XVIII ☐
Title XIX ☐
Other ☐

Facility _____

Physician ☐☐☐☐☐☐

II. Current Medical & Psychological Diagnoses

(One diagnosis per line)

1. Admitting/Primary diagnosis _____ ☐☐☐☐
2. Secondary _____ ☐☐☐☐
3. Tertiary _____ ☐☐☐☐
4. _____ ☐☐☐☐
5. _____
6. _____

DRAFT For discussion only

Date of Review ☐☐☐☐☐☐ M M D D Y Y

Method of Review: M.R. ☐ I.P.R. ☐

III. Surgical Procedures

1. Date ☐☐☐☐☐☐ Type _____ ☐☐☐
2. Date ☐☐☐☐☐☐ Type _____ ☐☐☐
3. Date ☐☐☐☐☐☐ Type _____ ☐☐☐
4. Date ☐☐☐☐☐☐ Type _____ ☐☐☐

IV. Mental Retardation Diagnosis Onset:

1. Infancy ☐
2. Developmental (below age 18) ☐
3. Age 18-65 ☐
4. Over 65 ☐
5. No record ☐

Severity:

1. Borderline ☐
2. Mild ☐
3. Moderate ☐
4. Severe ☐
5. Profound ☐
6. No record ☐

Admitted From:

1. Home ☐
2. Hospital ☐
3. USTS ☐
4. Long Term Care Facility ☐
5. State Hospital ☐
6. Other ☐

FOR UTILIZATION REVIEW TEAM'S USE ONLY

Effective Date: _____

Physician _____

(Reclassification Date) _____

Recommended Level of Care:

(IMR 4)	☐	SNF
(IMR 5)	☐	ICF Primary
(IMR 6)	☐	ICF Secondary
(O)	☐	Residential
(X)	☐	Other
(A)	☐	Absent from facility

(IMR 4)	☐	SNF
(IMR 5)	☐	ICF Primary
(IMR 6)	☐	ICF Secondary
(O)	☐	Residential
(X)	☐	Other
(A)	☐	Absent from facility

(M.D._____Nurse_____Recorder_____)

_____
Expiration Date

STATE OF UTAH

INDIVIDUAL DEPENDENCIES AND POTENTIAL

Function Status	Self Care	Some Help	Total Help	Can Not	Individual Program
Walks with or w/o aids					
Transferring					
Wheeling					
Eating/Feeding					
Toileting					
Bathing					
Dressing					
Self-preservation skills					

Mental Status	Never	Some-times	Always (Daily)		Individual Program
Alert					
Impaired Judgement					
Agitated					
Hallucinates					
Severe Depression					
Assaultive					
Abusive					
Restraint Order					
Regressive Behavior					
Wanders					
Other (Specify)					

Impairments	None	Partial	Total	Special Devices	Individual Program
Sight					
Hearing					
Speech					
Communications					
Other (Contractures, Etc.)					
Specify					

STATE OF UTAH

VI. DRUGS

	Name and Strength	Frequency Administration	Therapeutic Code	Drug Identification Code	
A				-	(1
B				-	(3
C				-	(4
D				-	(6
E				-	(7
F				-	(8
G				-	(1

Frequency Code	
1	1 qd
2	1 bid
3	1 tid
4	1 qid
5	prn
6	qod
7	other

Administration Code	
1	PO
2	IM
3	IV
4	Subcutaneous
5	Rectal
6	Topical

Therapeutic Code

03.	Analgesics, non-narcotics
05.	Antacids and Digestants
09.	Antiasthmatics
13.	Anticonvulsives
21.	Antibotics and Antiinfectious
49.	Antidepressants
07.	Antiarthritics - Antiinflammatory
15.	Antihistamines
31.	Antihypertensive
33.	Decongestants and cough
35.	Diuretics
91.	Food Supplements
36.	Eye Medication
41.	Hormone
17.	Hypo-glycemic
42.	Laxatives
43.	Miscellaneous
31.	Miscellaneous Heart Drugs
45.	Muscle Relaxant
01.	Pain - Narcotics
53.	Sedatives
87.	Topical Skin
51.	Tranquilizers
65.	Vitamins

I. INDIVIDUAL ASSESMENTS (DATA BASE) AND PLANS
(1-Present; 2- Present/Incomplete; 3- Absent; 4- Not applicable)

A. Medical Service
1. Complete medical evaluation including history, physical and diagnoses. ☐
2. Annual physical and history. ☐

B. Annual IDT (Inter-disiplinary team) assessment. ☐

C. Psychological Evaluation ☐

D. Social Service Assessment ☐

II. INDIVIDUAL RESIDENT RECORD
(1- Present; 2- Present/Incomplete; 3- Absent; 4- Not applicable)

A. Mini IDT assessment (90 days) (Plan of care review) ☐

B. Patient plan of care with short and long term goals ☐

C. Habilitation program for M.R. (Daily Schedule) ☐

III. DISCHARGE PLANNING

A. Discharge potential and plan
(1- Independent living; 2-Higher level of care; 3- Lower level of care (group); 4- No potential for discharge; 5- Other) ☐

IV. SPECIAL PROGRAMS
(Record appropriate number if individual is in a current program.)

A. Speech Therapy: 1- Programmed by therapist; 2- Evaluation desired; 3-Non-applicable ☐

B. Physical Therapy: 1- Directed by therapist; 2- Evaluation desired; 3- Non-applicable ☐

C. Occupational Therapy: 1- Directed by therapist; 2- Evaluation desired; 3- Non-applicable ☐

D. Behavior Modification Program: 1- Programmed by therapist; 2- Evaluation Desired; 3- Non-applicable ☐

E. Dental Assessment 1. In progress; 2- Evaluation desired; 3- Non-applicable ☐

F. Social Counseling: 1- Directed by CSW; 2- Evaluation desired; 3- Non-applicable ☐

G. Psychological Counseling: 1- Counseling by trained counselor; 2- Evaluation desired; 3- Non-applicable ☐

H. Psychotherapy: 1- Programmed by psychiatrist; 2- Evaluation desired; 3- Non-applicable ☐

I. M. R. Program (Daily Schedule): 1- Programmed by M. R. specialist; 2- Evaluation desired; 3- Non-applicable ☐

J. Activity Program: 1- Programmed by recreational therapist; 2- Evaluation desired; 3- Non-applicable ☐

K. Reality Orientation or Remotivation Program: 1- Current structured program--group; 2- Evaluation needed; 3- One to one only; 4- Non-applicable ☐

L. Special School Program: 1- Pre-academic; 2- Academic; 3-Deaf/Blind; 4- Multi-handicap; 5- Other_____; 6- Non-applicable ☐

M. Other Special Programs; 1- Recreational activity centers; 2- Vocational training; 3- Employment; 4- Non-applicable 5- Other_____ ☐

V. SEIZURES (UNCONTROLLED): If non-applicable please check this box - - - ☐
(1- 0/24 hrs; 2- 24/48 hrs; 3- 48/72 hrs; 4- wkly; 5- monthly; 6- periodic)

A. Frequency ☐

B. Medication Changes ☐

C. Falls that cause Injuries ☐

D. If Protective Measures are Used: 1- Helmet used constantly; 2- Helmet used occasionally; 3- Refuses to wear helmet; 4- One-to-one observation ☐

E. Would you recommend this resident for evaluation and/or admission to Seizure Control Unit? 1-Yes; 2-No ☐

VI. MEDICAL NURSING PROGRAMMING

A. Vital signs are taken and recordered:(1- Daily; 2- Weekly; 3- Monthly; 4- PRN)

a. Blood Pressure ☐

b. Weight ☐

c. Temperature-Pulse-Respiration ☐

B. Laboratory Work: 1- Non-applicable; 2- Present; 3- Needed--Type_____ ☐

C. Inhalation Therapy: 1-Yes; 2-No ☐

D. Oxygen: 1-Yes; 2-No ☐

E. Suctioning: 1-Yes; 2-No ☐

F. Postural Drainage/Percussion: 1-Yes; 2-No ☐

G. Therapeutic Diet: 1-Yes; 2-No ☐

H. Skin Care: 1-Yes; 2-No ☐

If yes--

a. Special measures to maintain health of skin ☐

b. Dermatitis, stasis ulcer, abrasions and other lesions ☐

c. Decubitus ulcer ☐

APPENDIX C

Reproduction of the

RHODE ISLAND

MEDICAL REVIEW FORM

(ICF-MR)

(Note: Each page of the actual form is a different color)

October, 1976

PATIENT-RESIDENT PROFILE

Medical Review
Prereview Form

1. FACILITY ______________________ ______________________

2. PATIENT-RESIDENT'S NAME

last

first

3. LAST RESIDENCE

______________________ *(street)*

______________________ *(city)* *(state)*

4. BIRTH DATE ______ *(month)* *(day)* *(year)*

5. ADMISSION DATE ______ *(month)* *(day)* *(year)*

IF ADMISSION DATE IS WITHIN LAST 12 MOS. ANSWER QUESTION 6 and 6a BELOW.

6. FACILITY ADMITTED FROM

____

6a. LEVEL ADMITTED FROM

1. SN___
2. ICF1___
3. ICF2___
4. Hospital, Acute___
5. Hospital, Chronic___
6. Home, Own or Relatives___
7. Other___ Specify:

7. MOST IMPORTANT CURRENT DIAGNOSES:

I. ______________________

II. ______________________

III. ______________________

IV. ______________________

8. MEDICAID # [ ]-[ ][ ][ ][ ][ ]

9. SOC. SEC. # [ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ]

10. SEX

1. Male___
2. Female___

11. RACE

1. White___
2. Black___
3. Other___ Specify:

12. MARITAL STATUS

1. Married___
2. Never Married___
3. Widowed___
4. Sep/Div___

13. PAYMENT

a. Primary Source: Medicaid___ (inc. P.A. & welfare) Medicare___ Other___ Specify:

b. If patient-resident receives Medicaid, please indicate "Level Certified" and "to date"

______________ to ______________
(level) *(mo.)* *(day)* *(yr.)*

Signed: ______________________

1. Pt Name LAST FIRST

2. Soc. Sec. No.

3. Medicaid

4. Pt. No.

5. Birth Date MONTH DAY YEAR

6. Pt. No.

MEDICAL REVIEW - (ICF-MR)
Rhode Island Department of Health

7. Facility

8. Pt's Last Residence STREET

CITY STATE

9. Address of Responsible Person STREET

CITY STATE

10. Sex
1. MALE
2. FEMALE

11. Race
1. WHITE
2. BLACK
3. OTHER

12. Religion
1. CATHOLIC
2. PROTESTANT
3. JEWISH
4. OTHER
5. NONE

13. Marital Status
1. MARRIED
2. NEVER MARRIED
3. WIDOWED
4. SEP. / DIV.

14. Birth Date MONTH DAY YEAR

15. Admission Date MONTH DAY YEAR

16a. Admitted From
1. SN
2. ICF1
3. ICF2
4. HOSPITAL - ACUTE
5. HOSPITAL - CHRONIC
6. HOME - OWN OR RELATIVES
7. OTHER

16b. Name of Facility

17. Present M.D.

18. Primary Payment Source
1. MEDICAID
2. MEDICARE
3. VA
4. PRIVATE CHARITY
5. INSURANCE
6. PRIVATE PAYMENT
7. OTHER

Level of Care
01. SN
02. ICF1
03. ICF2
04. RESIDENTIAL CARE
05. ICF-MR-COMMUNITY
06. ICF-MR-PUBLIC INSTITUTION
07. HOSP-GEN
08. HOSP-PSYCH.
09. HOME

19. Receiving

20. Certified

21. Recommended

22. Diagnoses
I.
II.
III.
IV.

23. ADL Score

24. Nursing Units

25. Review Date MONTH DAY YEAR

R.I. DEPARTMENT OF HEALTH

PATIENT'S NAME _____ _____
(last) (first)

PT. #

PT. # NURSING REVIEW FORM 8. inappropriate 9. no information ICF-MR

Services Reflected in the Record:

Code #1-#4 as: 1. yes 2. no

1. Are these complete and current:
   (a) medical diagnoses? (1)a____
   (b) medical treatment orders: revised or reviewed every 90 days? b____
   (c) written medical care plan? c____
2. Medication orders: administered, charted, signed? (2) ____
3. Nursing record:
   (a) plan of care: performed, charted, results noted? (3)a____
   (b) progress notes: complete & current? b____
4. Nursing care currently administered:
   (a) bladder/bowel retraining? (4)a____
   (b) tube feeding? b____
   (c) physio-therapy? c____
   (d) wounds/dressings? d____
   (e) regular injections? e____
   (f) skin care? f____
   (g) mechanical restraints? g____
   (h) chemical restraints? h____
   (i) numerous oral medication? i____

Personal Observation of Resident Status

5. Senses: (1. not impaired 2. partly impaired 3. completely impaired)
   (a) sight (5)a____
   (b) hearing b____
   (c) speech c____

Code #6-#14 as: 1. receives 2. does not receive 3. requires, does not receive

6. Ambulation aids:
   (a) crutches (6)a____
   (b) cane(s) b____
   (c) walker c____
   (d) wheelchair d____
   (e) one person e____
   (f) two people f____
7. Physical therapy (7) ____
8. Occupational therapy (8) ____
9. Speech and hearing therapy (9) ____
10. Oxygen or inhalation therapy (10) ____
11. Psychotherapy (11) ____
12. Dental care (12) ____
13. Podiatry care (13) ____
14. Special diet (14) ____

General Health: Code #15 and #16 as: 1. yes 2. no

15. Is resident confined to bed or bed-and-chair? (15) ____
16. Is resident:
   (a) clean? (16)a____
   (b) free from decubiti? b____
   (c) free from malnutrition or dehydration? c____
17. Appetite: 1. good 2. fair 3. poor (17) ____
18. Compared to condition at admission is his/her:
   (a) general health (18)a____
   (b) physical functioning b____

1. improving 3. unstable
2. stable 4. declining

Patient Placement

Code #19 and #20 as:
01. SN
02. ICF 1
03. ICF 2
04. Residential Care
05. ICF-MR-Community
06. ICF-MR-Public Institution
07. Hospital-General
08. Hospital-Psychiatric
09. Home

19. Recommended level of placement for resident now: (19) ____
20. Potential suggests eventual placement at what level: (20) ____

Signed _____ Date _____

10/76

R.I. DEPARTMENT OF HEALTH

PATIENT'S NAME _____ _____
(last) (first)

PT. # 8. inappropriate 9. no information

PT. # SOCIAL SERVICE REVIEW FORM ICF-MR

Services Reflected in the Record — Code #1-#4 as: 1. yes 2. no

1. Social and family history: current and sufficient? (1) ____
2. Social needs identified: complete and current? (2) ____
3. Care and management plan (Social Services): complete & current? (3) ____
4. Discharge plan or reason for continued care stated? (4) ____

Resident Adjustment and Functioning

5. Attitude toward care: (5) ____

1. cooperative 3. uncooperative
2. gen. cooperative 4. unresponsive

6. Resident's relationships with:
(a) staff — 1. good 3. poor 2. fair 4. unresponsive (6)a ____
(b) other residents b ____

Code#7-#10 as (approximately):
1. weekly 4. yearly or less
2. monthly 5. no known family or friends
3. quarterly

Family Involvement

7. Family writes, telephones (7) ____
8. Family visits (8) ____
9. Family takes resident outside facility (9) ____
10. Resident has outside contacts others than family (10) ____

Participation in Activities

Code #11-#19 as:
1. regular 4. unavailable
2. occasional 5. physically or mentally
3. rare or never unable to participate

11. T.V. and/or radio (11) ____
12. Reading (including talking books) (12) ____
13. Writing (letters, puzzles) (13) ____
14. Religious services (14) ____
15. Arts/Crafts (including O.T. and individual hobbies) (15) ____
16. Special programs (of facility or community groups) (16) ____
17. Trips & outside entertainment (facility or community) (17) ____
18. Other (18) ____
19. Are activities provided at resident's level of acceptance? (19) ____

Resident Placement

20. Services Needed for Return to Community:

1. service alone sufficient to permit return.
2. service(s) needed in concert in order to return.
8. service inappropriate or insufficient.

(a) O.P. medical or M.H. care (a) ____
(b) visiting nurse or P.T. (b) ____
(c) homemaker or home health aide (c) ____
(d) meals-on-wheels (d) ____
(e) adult day care (e) ____
(f) sheltered training or workship (f) ____
(g) sheltered housing (g) ____
(h) boarding or with relatives (h) ____

Code #21 and #22 as:

01. SN	06. ICF-MR-Public Institution
02. ICF I	07. Hospital - General
03. ICF II	08. Hospital - Psychiatric
04. Residential Care	09. Home
05. ICF-MR-Community	

21. Recommended level of placement for resident now: (21) ____
22. Potential suggests eventual placement at what level: (22) ____

Signed _____ Date _____

10/76

R.I. DEPARTMENT OF HEALTH

PATIENT'S NAME _____ _____
(last) (first)

PT. #

QUALIFIED MENTAL RETARDATION PROFESSIONAL REVIEW FORM

PT. # ICF-MR

Admission Information

Code #1-#9 as:
1. yes 8. inappropriate
2. no 9. no information

1. Jusitification/Certification for admission stated? (1) ____
2. Evidence in support of admission includes:
   (a) social history, including current life situation? (2)a ____
   (b) psychological evaluation by standard tests and/or observational procedures appropriate to individual: b ____
   (c) IQ below 69? c ____
3. Statement of alternative placement options considered? (3) ____

Post Admission

4. Treatment of habilitation plan (Plan of Care) given? (4) ____
5. Plan based on adequate assessment and reporting? (Should include reporting by direct-care person.) (5) ____
6. Plan adequate to individual in following areas:
   (a) Self-care skills? (6)a ____
   (b) Social skills? b ____
   (c) Communication skills? c ____
   (d) Work skills? d ____
7. Where appropriate, following services provided:
   (a) School? (7)a ____
   (b) Sensory-motor training? b ____
   (c) Speech and language therapy? c ____
   (d) Psychotherapy (including behavior modification)? d ____
   (e) Chemotherapy (psychotropic medication)? e ____
8. Is plan regularly reviewed and up-dated on the basis of continuing observation and assessment of resident's status and needs? (8) ____
9. Recertification every 60 days? (9) ____

Resident Placement

Code #10 and #11 as:

01. SN	06. ICF-MR-Public Institution
02. ICF I	07. Hospital-General
03. ICF II	08. Hospital-Psychiatric
04. Residential Care	09. Home
05. ICF-MR-Community	

10. Recommended level of placement for resident now: (10) ____
11. Potential suggests eventual placement at what level: (11) ____

Signed _____ Date _____

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